Authorization for the Release and/or Discussion of Protected Health Information

Full Name: _____ **Birth Date:** _____/_____/_____

I, _____, hereby authorize the following:

Name of Person or Organization: _____
Relationship:_____
Street Address: _____
City, State, Zip: _____
Telephone: (_____) _____

To release and/or discuss the following information:
☐ **Complete Record** ☐ **Pathology/Labs ONLY** ☐ **Billing**

Other: _____

Records may be: ☐ Mailed To ☐ Faxed to number below

To: **Enlighten Dermatology and Wellness**
Amy Wolthoff, MD
6190 LBJ FWY, #200
Dallas, TX 75240
Phone: (817)985-7685 **Fax: (833)337-6329**

This information release is at my request for the purpose of medical assistance.

I have carefully read and understand the above information and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

PLEASE CIRCLE: This authorization expires 6 MONTHS / 1 YEAR from today's date, or upon the following specified event: _____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signature:_____ **Date:**_____